ImpAct

- sharing experience
- defining good practice
- improving service delivery
- supporting learning in the NHS

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NHS Learning Network

It's the little things that matter

When we talk to people in primary care about ***Bandolier*** and ***ImpAct*** it's often the small things that bother them, how can they find time to do X, why Y takes us so long. It's not the big ideas but the trivial machinations that prevent people getting on with the job. This issue of ***ImpAct*** concentrates on work in primary care. Two of these case studies cover activities that may often seem to drop off the agenda when people get into discussions about policy and strategy.

Manor View practice has shown that a sensible local initiative can reduce the use of antibiotics in children and with careful thought can act as a catalyst to help the practice learn how to do other things better. It shows similar reductions in antibiotic prescribing (about 50%) as did a US initiative reported on in ***Bandolier*** 77.

Nunwell practice has shown that work to tackle the hoary old problem of leg ulcers can be successful in healing ulcers. More importantly it shows how, using best evidence, much nursing time can be saved doing the right things right. It is so often the case that best practice is also cost-effective practice.

At the other end of the spectrum the work in Dorset on the **SUCCEED** project has shown the merit of countywide work to provide a framework for local action. It showed that the minor irritations of trying to do a good job **could** be overcome by planning information and resources, and then getting on with it. It helped to make the work at Leybourne practice do-able by providing the information necessary. Ambitious targets for cardiac care were met, and confidence generated to improve those targets even more for the future.

Feedback is always helpful. Let ***ImpAct*** know if you have successful projects worth telling others about, and what topics you want help with.

In this issue

Promoting interest in evidence-based practice in primary care

Learning from an initiative at Manor View Practice in Bushey to reduce the use of antibiotics in children with ear infections

Why was the initiative launched?

In May 1997 a Cochrane review published in the BMJ questioned the use of antibiotics as the initial management of acute ear infections (otitis media) in children. At the time, Chris Cates, a partner in a training practice in Bushey was becoming involved in the work of the Cochrane Collaboration. The practice served about 11,000 patients with few from ethnic backgrounds. Information about prescribing in the practice suggested that about half of the antibiotics given to children were for acute otitis media.

What was done?

The six partners agreed to explore ways to use the results of the Cochrane review: *could the practice reduce their antibiotic prescribing level*? After some discussion they decided to continue to offer prescriptions to parents - but ask them to delay using it for a couple of days. They foresaw that refusal of a prescription at a first appointment might simply prompt more appointments. A deferred prescription might give parents confidence to wait and see if their child improved without the use of antibiotics.

They chose to tackle the initiative allowing each GP to adopt the new policy at their own pace. They decided not to write their new policy as a guideline or protocol: this would require agreement on a definition of otitis media, not felt to be feasible in a rapidly changing condition. There was also a feeling that the preparation of a guideline might simply encourage partners to avoid the diagnosis of otitis media and use a related condition as the argument for prescribing antibiotics. The discussion had prompted awareness of the evidence and the issue: this was argued to be sufficient.

Persuading parents

Chris Cates prepared a draft handout for parents to persuade them of the merit of the new approach. It explained the results of the research and the recommended treatment, ie the use of paracetamol to reduce the pain and antibiotics if the symptoms persist. The handout was modified fol-

lowing suggestions from partners and made available for the use in July 1997. GPs were given a supply of the handout and encouraged to use it. They were not then asked to make any other changes to their approach, and in particular not required to keep separate records of their actions.

The new policy was soon seen to be having an effect. Responses from parents were favourable. The change in policy was not causing any problems. The practice decided to look for ways to measure the impact of their efforts and find out what was happening to the deferred prescriptions. In October 1997, Roseanne Whitfield, a registrar attached the practice needed a project as part of her training programme. It was agreed that she should contact a sample of parents to check whether the prescription had been used. Also a local practice agreed to act as a control and allow information about their prescribing levels (PACT data) to be analysed. The practice is about the same size with a similar group of GPs and patients and, like Manor View, uses amoxycillin as the antibiotic of choice in children with otitis media. The control practice, although aware of the evidence, was not planning specific action to change their prescribing policy.

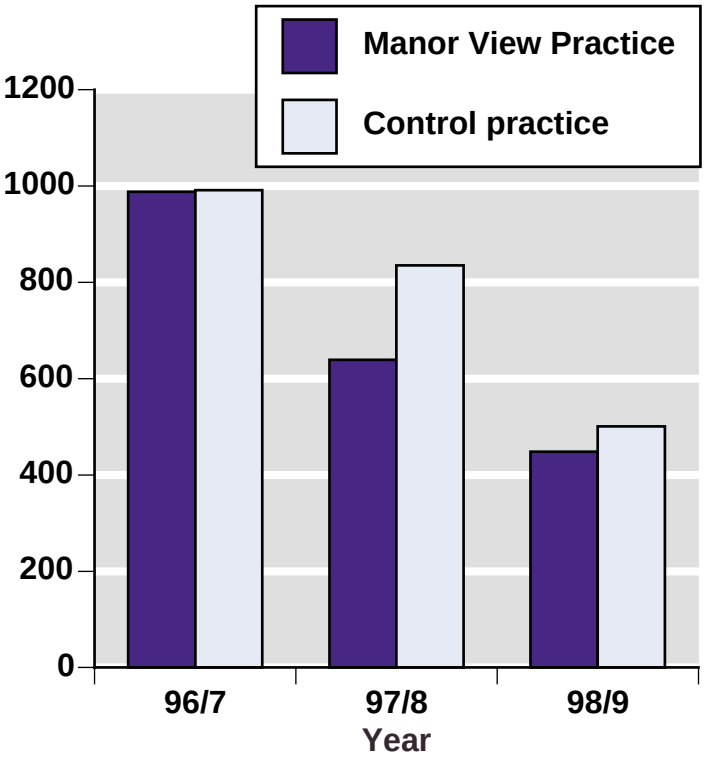
Did it work?

The effort involved had an encouraging impact on prescribing levels and has given the practice a real sense of achievement. Quality of care has improved and parents support the changes. Success with the antibiotic initiative was reflected in the award of Beacon status in 1999. More significantly the work has prompted important changes in the way the practice looks at the evidence for the care it provides.

Were parents listening?

All the partners were asked to keep records for two weeks of patients who consulted with otitis media and whether an antibiotic prescription, for deferred or immediate use, was given. The GPs saw 24 children over the two-week period. Patents of 19 of these could be contacted one week later. Seven parents advised to use the prescription immediately and all had done so. Two of the eight parents given a prescription but advised to hang on to it used it immediately: the other six waited and did not need to use it. Parents of four children were not given a prescription. No children returned for further treatment. Although small numbers were involved the results were encouraging. Parents seemed to be heeding the advice given.

Figure 1:
Amoyxcillin suspension prescriptions



What was the effect on prescribing levels?

Support from the health authority and the PPA was enlisted to help compare prescribing levels between the practice and the control practice. A search of practice records had shown that the majority of prescriptions for amoxycillin were for otitis media, the use of other antibiotics for otitis media balanced the use of amoxycillin for other conditions. Prescribing levels were compared for the twelve months before the use of the handout for parents was available and with the two following years.

The initial impact was marked. Over the first six months the total number of antibiotic prescriptions for children was about 20% lower than in the same six months the previous year. To help them see more clearly the impact of their work over a longer period and allow for seasonal variations in

Table 1: Prescriptions for amoxycillin suspensions

	Before the change in policy 1996/7	First year 1997/98	Second year 1998/99
Median number of prescriptions per month.			
Manor View Practice	75	47	35
Control practice	72	66	39
Total number of prescriptions per year			
Manor View Practice	988	639	448
Control practice	991	835	501

prescribing levels the practice calculated monthly and annual rates (using suitable statistical techniques) - see Table 1 and Figure 1. More detailed graphs to illustrate the rates of change are included on the ***ImpAct*** website. These show an encouraging downward trend. There was a big difference in the first year of the intervention but prescribing in the control practice has also reduced. Anecdotal evidence suggests a 'playgroup' influence – word seems to have been spread by parents about the merits of the new policy. Additionally the control practice has set out to see if they could also achieve a similar reduction when they saw the results of the new policy.

Can we build on our success?

Progress with the initiative has encouraged the practice to look for other ways to improve the quality of their care and treatment of patients. Time is now set aside for a half-hour meeting every other week to address topical issues. Initially the meetings involved only the GPs in the practice but invitations are now being extended to nursing staff.

The agenda is drawn up and a range of issues addressed. Clinical issues include the treatment of sinusitis (based on a Cochrane review like the work on antibiotics), the use of post-coital contraception, the use of a new spirometer in the asthma clinic. Other issues include ways to improve appointment systems and the displays in the waiting room.

Partners and nursing staff adopt topics and agree to investigate the background and provide presentations to their colleagues. This task of preparation and presentation is proving to be a useful personal development opportunity for those who have not been used to such work. The meetings are popular and productive. After reviewing the evidence the use of the Yuzpe method of post-coital contraception has been abandoned in favour of Levonorgestrel alone.

Tips for success

- √ Ensure that all clinicians are involved from the outset: don't leave out colleagues who can reinforce the messages to parents, such as health visitors
- √ Avoid making meetings the key stepping stones to progress. Make full use of informal opportunities to talk, such as over coffee, and in the corridors
- √ Use posters in surgeries and other leaflets to get the message over to parents.
- √ Look for ways to use graphical illustrations in handouts for patients: don't rely only on words alone
- √ Look for ways to demonstrate progress like quick local surveys of patients' reactions.
- √ Keep the process simple and don't add to the burden of record keeping.

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The handout for parents can be downloaded from Chris Cates' website and be adapted freely for your own use.

ImpAct bottom lines

⇒ Be openly incremental: make plans to build on successes and encourage further development

MAKING BETTER USE OF NURSES' TIME

Implementing effective treatment for leg ulcers at Nunwell Surgery, Bromyard, Herefordshire

Why was the initiative launched?

In 1997 one of the District Nursing team working with the Nunwell Surgery was working on her conversion course from EN to RGN. She chose to investigate the management of leg ulcers as one of the assignments for her course. Apart from looking at the current arrangements for managing patients locally she assembled evidence about effective treatments. Her conclusion was that although the use of compression bandaging was a proven technique the management locally of venous leg ulcers was haphazard and ineffective. Ways needed to be found to improve quality of care.

What was done?

Discussing the results persuaded the practice team that something had to be done to improve the situation. The four district nurses from the community Trust who worked with the practice agreed to take part in an initiative. Work was put in hand to tackle four tasks.

First, to develop a local protocol to guide the nurses in the assessment of leg ulcers. Based on the available evidence this was designed to ensure that nurses could distinguish between venous and arterial ulcers. The objective was to treat venous ulcers within the practice and ensure that arterial ulcers were referred swiftly to the local Consultant Vascular Surgeon.

Second, to select a small pilot group of patients. The challenge was not only to identify the patients who it appeared would benefit from the use of compression bandaging but also to persuade them to take part. Care had to be taken to balance the long term benefits, increasing mobility and getting rid of the smell, against the short term discomfort and possible additional pain from the compression treatment. Not all patients were keen to take part: many had got used to their ulcers. Eight patients agreed to take part.

Third, arrangements for suitable training for the four district nurses. This was difficult because training funds were scarce. The practice agreed the practical way froward was to accept offers from two pharmaceutical representatives to cover the costs of two types of study days. One was concerned with ensuring that the nurses had the skills to undertake proper assessments using Doppler equipment. The other was to ensure that nurses had the skills to apply compression bandaging. These sessions were effective in developing the skills of the district nurses.

Fourth, ways had to be found to cover the short term costs of additional multi-layer compression bandaging which at the time could not be prescribed but was available on the FP10. The practice agreed to fund the initial costs from savings on the fundholding budget. Subsequent changes allow compression bandaging to be prescribed.

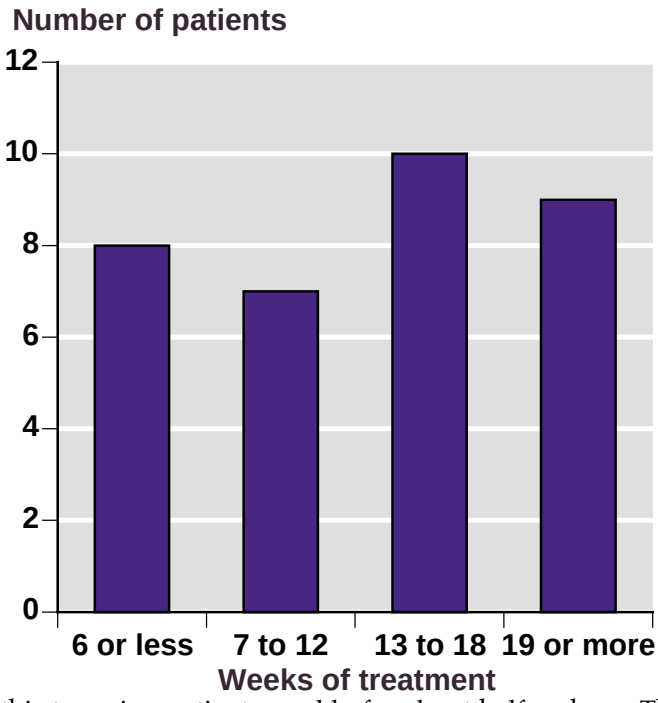
Did it work?

After their training the four district nurses started to apply their new skills in April 1998. A thorough assessment of the patients was undertaken which in addition to the necessary Doppler investigation included photographing and tracing the ulcer to determine its size. Very soon the success of their work became apparent: ulcers were healing and the nurses' precious time was being saved. With hindsight the practice recognised that they could have done more to lay plans to measure the benefits of the work. Nevertheless the impact of the work was visible to patients, nurses, and general practitioners. This success was acknowledged when the practice was awarded Beacon status in 1999.

Impact on nurses

Before the initiative was launched individual nurses would be spending time changing dressings daily, perhaps up to two hours per patient per week. This old fashioned treatment was costing between £30 and £40 per patient, depending on the materials used (Table 1). The initiative reduced this to seeing patients weekly for about half an hour. The costs of the evidence-based approach are about £13 per patient per week (time and materials). The time saving has allowed the development of new services including an asthma clinic. The success persuaded the practice nurses to get involved and additional study days were laid on to help them build up their skills. The initiative had a positive effect on the morale of nurses working in the practice.

Fugure 1: Healing times for patients with venous leg ulcers



Impact on patients

Patients are increasingly pleased with their progress. Between January 1998 and May 2000, about 50 patients have been treated. Many of these had suffered with ulcers for many years or had more that one ulcer. Three quarters of these have been healed and on-going care is currently being provided for 13 patients with most of these progressing towards healing. Some of the ulcers took well over a year to heal, but many others were healed within six weeks (Figure 1). One patient, a man in his '50s had suffered with ulcers for over 20 years applying his own dressings. He had been reluctant to seek treatment for an "old ladies" complaint. Following the intervention of a friend, an assessment confirmed the presence of venous ulcers and treatment was started. The ulcers quickly became less painful and one ulcer has healed and the other virtually healed.

Table 1: Nunwell Surgery: broad comparative costs (£) for treatment of leg ulcers

	Old Method 1 Iodine plus dressings	Old Method 2 Ointment plus dressings	New Method Evidence-based compression
Dressings and materials	11.00	19.90	8.25
Labour costs	20.00	20.00	5.00
Total costs	**31.00**	**39.90**	**13.25**

Impact on GPs

Nurses have undertaken the bulk of the work involved in the initiative but the work has had a significant impact on GPs. Compared with attitudes before the work started, there is now a real sense that something can be done for these patients. The initiative also had a noticeable effect on relations with the local hospital. The Consultant Vascular Surgeon has complemented the practice because he is now getting the right patients, those who needed his attention.

Two problems remain. A few patients cannot handle compression therapy. Two patients refused to carry on, one because it was too painful, the other because it was taking too long. It requires stamina and can take many months to heal a large ulcer and patience is required. It is proving difficult to maintain continuity of treatment for the ulcer when patents are admitted to hospital for other conditions. Nursing staff in hospital may not have the skills and support to allow them to apply the same treatment regime. Discussions are in hand to seek ways to tackle this situation

Tips for success

- √ Good teamwork is essential for effective care with clear recognition about relative roles. Don't try to increase nursing responsibilities unless they and GPs have confidence in the proposed approach.
- √ Take time and patience to explain the benefits to patients but don't gloss over the inevitable pain they will have to endure as compression takes effect.
- √ Basic skills in assessment and the application of compression bandaging are essential. Find practical ways to enable nurses to build up their skills.
- √ Improving the quality of primary care can improve also relationships between primary and secondary care.
- √ Make plans before you launch initiatives to decide how you will measure success

For more information contact a member of the team

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The following material is available

Training notes: management of leg ulcers in primary care using compression therapy

ImpAct bottom line

⇒ Significant timesavings for hard pressed nursing staff can be an important spin off from the implementation of effective treatments

How to 'succeed' with cardiac care in primary care

Developing a framework for Successful Cardiac Care based on Evidence for Effectiveness in Dorset (SUCCEED).

Why was the initiative launched?

A number of studies in 1996 raised questions about the quality of secondary prevention of ischaemic heart disease in primary care in Dorset. Growing research evidence was showing the benefits of tackling risk factors such as lifestyle and the control of hypertension as a way of reducing morbidity and mortality. But this was not the reality of everyday practice. At the same time Dorset Health Authority was looking for ways to change the methods of funding health promotion clinics in primary care to focus more on outcomes and efficiency: were resources being used effectively?

A small group of general practitioners and nurses from across Dorset, led by Dr Graham Archard, decided to try to help practices improve the quality of their cardiac care. The challenge was to create a mechanism that would stand the test of time and not gradually fade away like so many other initiatives. Could they develop evidence-based standards and help practices to implement change?

What was done?

The project group's first task was to draw up a project plan including agreement of clinical standards, a mechanism for delivering messages to practices and steps to measure the impact of their work. Additional staff and resources (such as training material) would be required.

Working with a pharmaceutical company

After some debate the group decided to ask a pharmaceutical company (Merk, Sharpe and Dohme) for financial support. Terms for the company's involvement and funding were agreed for three years. They would be represented at general meetings but have no clinical input to the work. The project would not promote the medications from any particular company. Funding would cover a half-time rehabilitation nurse, sessional costs for the Project Director and members of the proposed Steering Group, the costs of accommodation for training meetings and related training material. Funding also covered the costs of creating posters to promote the SUCCEED project. The group devised a logo to give a sense of identity for the work.

Creating a care pathway

Work then started in earnest to create a set of county standards for cardiac care in primary care. The group decided to present this as a care pathway and base it on the Oxford model. The pathway would apply to care following coronary artery bypass grafting, coronary artery angioplasty and would apply following acute myocardial infarction. Three stages were planned. Stage 1 would focus on newly diagnosed patients. Stage 2 would pick up patients with a his-

tory of cardiac events. Stage 3 might follow and tackle patients at risk of developing heart disease: primary prevention. Taken together the work would create a practice-based register of cardiac patients

The pathway would cover the collection of data on history, medications and lifestyle and offer a sound basis for auditing progress. Patient care would be personalised through patient record cards and represent a contract between the patient and the care manager. When a draft care pathway was ready the group invited all practices across the county to an initial meeting to talk about the plans. The meeting would provide a forum to review the care pathway and an opportunity to invite nominations for a SUCCEED Steering Group. Involvement with the project would be acceptable to the health authority in the context of health promotion funding. About half of the practices in the county were represented at the initial meeting.

Talking to practices in Dorset

The meeting stimulated extensive discussion about the pathway and eleven drafts were circulated before it was adopted as a working document for use from 1st April 1997. Three evening meetings were arranged to explain what would be involved if practices joined the project. The meetings were open to all practice staff. The agenda covered the evidence-base for the pathways, why the initiative was important and the work involved at practice level.

Practices were given the options of working incrementally (starting with stage 1 before moving on to stage 2) or tackle both stages together. A separate fast track committee was set up representing by eight practices to develop the care pathways and alterations in care pathways and then pilot them. A key consequence of the three meetings was the identification of local care managers (a GPs or nurse) who would lead the work within individual practices. They would identify the patients and develop personalised packages of care with them.

Getting the work done within practices

Once care managers had been identified they attended a training day at which all the steps in the care pathway were explained. Hospital cardiac rehabilitation nurses, pharmacists, GPs and practice nurses led the teaching sessions. The agenda for the day covered all aspects of the pathways as well as the practical tasks of identifying, from practice records, the patients who would need to be seen.

Care was taken to ensure that practices knew what this meant and how many patients would be involved. Data suggested that each practice would treat about 18 new MIs each year. The review of individual patients in either stage 1 or stage 2 was expected to take about 30 minutes. Project nurses' time was allocated time to individual practices to help them with this task. The pathway has been converted into a patient-held record card. This is now used extensively across the county, for example it is now used within hospitals and patients are increasingly discharged with their card.

Did it work?

Since the project was launched in June 1997 there has been a gradual increase in the number of participating practices. SUCCEED has been particularly well received by nurses in primary care. It has precipitated the creation of nurse-led cardiac care clinics. A description of the experience in one practice as part of SUCCEED follows in a brief case study: ***Tacking cardiac care: being part of SUCCEED***

By June 2000, 84 out of the total of 109 practices in Dorset were involved (Table 1). Over 1,000 patients have been brought within the pathway model of care. Local audits have been able to measure significant improvements against key interventions. Using published research and NNTs it is estimated that 22 deaths, 39 re-infarctions and 1 non-fatal strokes are being prevented in Dorset each year.

Patients have almost universally welcomed the project. They have indicated their support for involvement in their own care and, indeed, Dr Archard had one letter form an irate patient asking why the practice (who had decided not to be part of SUCCEED) with which they were registered 'was not allowed to take part'! The popularity of the project with patients is demonstrated by the low drop out rate (Table 1).

Table 1: Getting Involved - progress with SUCCEED: Summer 2000

	Acute MI	Cardiac angioplasty	Coronary artery bypass graft	Total	Percent
No of patients presented April 97/March 98	183	25	95	303	100
No of patents entered Care Pathway	154	21	75	250	82
No of patents stopped attending Care Pathway	16	0	9	25	10
121.25 GPs from 38 practices					
No of patients presented April 98/March 99	260	38	128	426	100
No of patents entered Care Pathway	197	26	145	368	86
No of patents stopped attending Care Pathway	45	5	12	62	17
157 GPs from 48 practices					

Building on early progress

The approach developed by SUCCEED has now been adopted by Poole and Bournemouth Hospital Trusts. Both now discharge patients following significant cardiac events with the patient-held record cards. A link rehabilitation nurse, funded by the British Heart Foundation, now follows up hospital discharges to ensure continuity in primary care. The project has been given a further boost following its inclusion, as an example of good practice, in the Cardiovascular National Service Framework.

The project continues to provide a practical framework for development in Dorset. Arrangements are in place to provide practice-based training as other practices in Dorset ask to join in and to ensure that training is available for new staff joining the practices already working with SUCCEED. Following the initial three-year funding from Merk, Sharp and Dohme, the project is now being jointly financed by Bayer, Pfizer, Parke Davies and Bristol Myers Squibb. There are encouraging signs that SUCCEED will not simply become another project rapidly forgotten, but rather a practical way of working across practices.

A more recent success has been the agreement to set up a mirror project to tackle diabetes across Dorset. This new programme of work, again funded in partnership with pharmaceutical companies, will have a research arm as well as the work to improve the standards of care to patients.

Tips for success

Improving cardiovascular care is on the agendas of all the new organisations being established in primary care. SUCCEED has shown that common standards can be agreed and implemented but those improvements have a price. People must be in place to co-ordinate the work, to provide necessary training and provide hands on help at practice level.

Specific points that merit attention are:

- √ Don't expect everyone to be enthusiastic. Maintain a regular flow of information about progress to all those involved. Avoid the question: *"Is that project still going?"*
- √ Finds ways to present the impact of the work on GPs and practices. How many of their patients are likely to be involved? *What does it mean for them?*
- √ Explore funding opportunities with pharmaceutical companies who may be willing to fund work in ways acceptable to clinicians.
- √ Create realistic expectations of practices and do the homework. Which office procedures and systems do they use? Do they have the staff time to get involved?
- √ Get hospital staff involved in the work from the beginning. Use of a patient held record used in primary and secondary care might help.
- √ Don't let continuing staff turnover undermine your efforts. Create a training package to help ensure new staff adopt the approach you have striven to introduce.
- √ Explore ways to talk through your plans with patients. They may have helpful ideas about how to get the messages over.

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The following material is available:

- SUCCEED project report
- Cardiac Care Pathway with recommendations on data collection.
- Patient record card
- Calculations of projected outcome from the SUCCEED project from NNTs.

ImpAct bottom line

⇒ External funding can strengthen the identity of and assure independence for project work.

TACKLING CARDIAC CARE - BEING PART OF 'SUCCEED'

How did they tackle the demands of SUCCEED at Leybourne Surgery, Bournemouth?

Leybourne Surgery joined SUCCEED when it was launched in 1997. Andrew Foot, one of the two partners, had been involved as the project started to take shape. He was nominated as care manager. His earlier involvement meant he could explain the requirements to his colleagues.

What needed to be done?

Interrogation of electronic patient records proved reliable and enabled the practice to readily identify the patients (220) who would need to be assessed within the pathway. Using an established template in the system these records provide a validated practice-based ischaemic heart disease (IHD) register. At about 6% of the practice population this is marginally higher that national levels.

Table 1: Audit of SUCCEED at Leybourne Surgery

Percent of patients with:	Target	Actual May 2000	Previous year	New Target for 2002
Aspirin prophylaxis	80	**83**	73	**85**
Cholesterol <5.0 mmol/L	70	**58**	46	**70**
Blood pressure <140/80	90	**95**	85	**97**

The challenge was to find ways to manage the reviews of the patients within the context of a busy practice. They decided to tackle this in two ways. First, be opportunistic and review IHD patients who attended surgery for any reason. Second, to invite groups of patients to a series of evening sessions. The aim was to invite (by letter) groups of about 20/30 patients to each evening session.

Time was be set aside before the sessions for a team briefing to ensure that all those involved understood their role and that of other members of the team: *all singing from the same hymn sheet*! The sessions would start with short talks to explain the reasoning behind the pathway. Practice staff (GPs and practice nurses) and other local staff (district nurses, therapists and dieticians) were involved, as well as the SUCCEED project nurse. After the introductory talks patients were seen individually to review their treatment. A patient-held record card was completed to define what was expected of the practice and the patient.

What improvements have been made?

Between Autumn 1997 and Summer 1999 the practice reviewed the treatment of **all** their IHD patients. Four evening sessions were needed to accommodate about half of the patients on the register. About 80% turned up to their allocated evening session. The remaining patients were seen as part of normal everyday business. The accommodation costs of the evening sessions were met by Merk, Sharpe and Dohme as part of their sponsorship of SUCCEED.

A recent audit of the patient records has demonstrated the progress being made – three key parameters are shown in Table 1. Two particularly difficult aspects have been smoking and weight. When people stop smoking they tend to put on weight. The practice has found that individual counselling with the GP is the most effective method of helping patients deal with this. They are also looking at a role for a specialist IHD nurse

The availability of the IHD register provided a good starting point. Ensuring that all IHD patients were reviewed within the pathway has added to the pressures on practice staff. It was difficult to find the time required. The strength of the evidence and acknowledged benefits of better cardiac care was persuasive: it was an aspect of primary care where staff could really make a difference. They could save lives and improve health. Because of this there have been no major problems. The work has given a welcome new role to practice nurses. Patients have liked the evening sessions and have responded positively to the use of the patient-held record.

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ELECTRONIC IMPACT

The limits of space in the eight pages available every two months reduces the number of projects we can write about. Those which cannot be accommodated on paper can now be found on the ***ImpAct*** Internet site (www.ebandolier.com/impact). Two case studies recently added are from Cornwall and Berkshire.

Community assessment and rehabilitation teams in Cornwall discusses the development of multidisciplinary assessments which cross the boundaries between health and social care. Two teams are now operational. They were some of the earliest community rehabilitation teams to be established. They offer rehabilitation to people over 16 years of age with temporary or continuing disability at home, in residential or nursing home care or other appropriate community setting.

Integrating three different aspects of mental health services for patients led to the creation of a development project based at Brookside, a large group practice in Reading. The project explored ways to improve links between the primary health care team, the community mental health team, specialist hospital based services and other community agencies. Provision of mental health services was reviewed to provide education, training and support for members of the primary health care team.

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